American College of Emergency Physicians®

May 2024

The Explorer

Exploring Retirement ACEP Section Newsletter

Steve Anderson, MD, FACEP
skkanderson@comcast.net
Section Chair

Fred Dennis MD MBA FACEP
fred@healthspan.guru
Section Vice-Chair

Pamela P. Bensen MD, MS FACEP
icd10MD@gmail.com
Newsletter Editor

Sandy Schneider, MD, FACEP
sschneider@acep.org
ACEP Staff Liasson

Burnout Edition, Fred Dennis, MD, FACEP Topic Editor

Announcements:

We're planning a Section Zoom on June 17th at 6:30 pm EDT.

There's time to add to the agenda. **REMAIN RELEVANT** and send us your ideas.

- Volunteers for the Councilor position in Vegas
- Discuss a bylaws resolution from the Section to secure ACEP financial transparency and stability
- Wiegenstein Legacy contribution of Dr. Thomas Pinson 0K to EMF is an example of the original dream of the Wiegenstein Society
- Introduce the concept of 'Exploring' segments at our meeting

~~~~

The Explorer is back!

The mission: To impart our experience and wisdom to our younger selves to assist their careers and lives.

The goal: to publish a topic oriented Explorer in odd months. I will be reaching out to section members to be the content agent for a theme, and Fred has kindly assented to take on the mission for our May issue.

~~~~

Physician Burnout – a Personal Commentary
Fred Dennis, MD, MBA, FACEP

Welcome to a topic focused edition of our Exploring Retirement newsletter. As you can see, it deals with physician burnout. Burnout is not confined to just emergency physicians, although we tend to be the most burned out of any specialty. So, the comments are from a variety of physicians and a clinical psychologist who has been involved with employee counselling.

As always, we welcome feedback including personal experiences. It is especially valuable, if you have faced burnout, to share approaches that have worked for you. And, if you are willing, we will share them with the Section.

The term "Burnout" dates to at least 1974 when Herbert Freudenberger published his book, *Burnout: The High Cost of High Achievement.* He defined burnout as "the extinction of motivation or incentive, especially

where one's devotion to a cause or relationship fails to produce the desired results."

There are multiple other burnout definitions, but they generally describe symptoms and provide no help in dealing with the problem; much like defining pneumonia as a disease characterized by cough, fever, sputum production and chest pain. How do you treat the disease if you cannot define it?

I prefer to think of burnout occurring when the external environment overwhelms a person's ability to cope. This gives us two directions from which to attack burnout. First, by directly addressing the Etiology and reducing the stress of the external environment. Second, by fortifying the individual by increasing the personal ability to cope.

It is estimated that the Black Death Plague in Europe affected about 50% of the population. Burnout in physicians affects at least 60% of us, with emergency physicians consistently the most burned out of any specialty. And, unfortunately, the external environment we face at work, at home, in society, and on every front is becoming more difficult.

When commuting in LA, I mentally assign a craziness index to each day. The number of times I get cut off, the deliberate slow drivers boxing me in, etc. gives me an idea of how my day will go. The same lack of societal civility is found in our EDs with demanding, out of control, self-centered patients increasing year by year.

Colleagues in every specialty tell me that increasing administrative burden is the most difficult part of the job. This drive to document and meet ever increasing criteria has less to do with improving patient outcomes and more to do with increasing RVU's per hour. The problem is compounded by the consolidation of physician practices and management of physicians by private equity ventures without physician, never mind personal, input.

Christina Maslach has been a pioneer in popularizing burnout and especially standardizing its measurement with her "Maslach Burnout Inventory." In her recent book, *The Burnout Challenge*, written with Michael Leiter, she states, "We believe burnout arises from the increasing mismatch between workers and workplaces." This is no longer debatable. Burnout is not a personal failure on the part of the physician to "just toughen up." And the solution is not just "more yoga."

A workplace which drives a wedge between the doctor and patient removes from us the satisfaction and enjoyment of knowing we are helping people. Helping is, for most physicians, the reason we got into medicine in the first place.

Worse, the inability to help patients can even lead to "moral injury." Moral injury was originally applied to military personnel in relationship to transgressing moral beliefs and values during wartime. It is now being diagnosed in healthcare workers when they are unable to help patients due to time or resource constraints. And it is crushing when it happens.

What can be done to reduce external stressors? If you have the energy, especially if you can build group consensus that it is a problem, you can try to change your work environment.

You must get buy-in from the top, whether the president of your group or the CEO of the hospital. Without this, you will be doomed to failure. Making the kind of changes that are necessary to empower physicians takes time and energy. And most leaders of hospitals and physician groups are stretched thin with issues they believe have higher priority.

In my experience, another 'must have' is a chief wellness officer who is a physician. Reducing physician burnout has a positive financial ROI (see AMA Steps Forward®), but it takes dedication to

"Increase shareholder value" should not be the gold standard for care provided to patients by physicians!	gather initial data and then track it to demonstrate the benefit.
This is not committee work. As with any change process, you need to get baseline data; on percentage of burned-out doctors, resignations, patient satisfaction scores, patient complaints, malpractice reporting, medical errors and more. All of these will be positively impacted with a successful burnout program. So, what about 'toughening up', building up resilience, something emergency docs have had to do since residency or even earlier? Night shifts, schedules that flip from nights to days to mid-shifts, managing multiple patients simultaneously, seeing people at their worst both physically and mentally, and dealing with death and disability daily - you must understand that to survive you need to take care of yourself with attention to diet, exercise, sleep, stress reduction etc. But there are limits, especially if you have young family and significant debt. **What is the solution?** If you are facing burnout, you need to take a personal inventory of your life and ask, and answer, some tough questions. The primary questions: **Am I in the right job? Do I like my work?** This includes honest answers to: -Is medicine where my heart is? i.e., versus a startup or real estate or a franchise -If medicine is right, is working in an ED the right place for me? i.e., versus urgent care/primary care/sports medicine -Is this the right location? i.e., rural vs. urban, coastal state vs. midwest or … -Is this the right practice setting? i.e., community hospital vs. academic center vs. trauma center	-Do I like and respect my boss? (everyone has a boss, even the contract holder) -Do I like the people I work with - docs/staff? Secondary questions can include: -Where do I want to be in 5 years, doing what? How about 10? -What is the minimum amount of money I/my family can live on? -Do I have the right partner/spouse? -Do I have the right "friends"? -Am I clinically depressed? Or even worse, addicted or worst, suicidal? -Should I get help? (Due to draconian laws/ regs on reporting, consider professional counseling using cash, not health insurance, out-of-town or even out-of-state.) An observation, by members of our ER Section, is that virtually everyone who is still engaged **had a side gig**, anything from committee work to education of healthcare workers to being a sports team doc. As Greg Henry says to graduating residents, "Congratulations, now you've made it. What's your exit strategy?" We'd love to hear your burnout exit strategy. Share the personal stratagems you've developed to cope with burnout. My belief is that once we recognize burnout, we realize we've faced it previously, shifted gears, and moved on. **How did you do that?** All comments no matter short or long welcomed. Please send to: Fred@healthspan.guru and indicate if you are willing to have us include them in a later issue of this newsletter.

-Am I working too many shifts? If so, how many fewer is right?

-Are these the right shifts? Are there too many nights/weekends/holidays?

Disclaimer: The above comments are my personal opinions and do not represent those of ACEP or organizations I have or am working for.

~~~~

Grief shared is half grief;

Joy shared is double joy.

– Honduran Proverb

Thoughts On Physician Burnout
Moe Gelbart, PhD

A great deal has been written and discussed regarding physician burnout. It is not only a reality, but a crisis in our healthcare system. Almost two thirds of physicians report burnout, as evidenced by low energy, exhaustion, anxiety, and reduced efficiency. It is not only the physician who experiences the difficulties, but the staff, the organization, the patients, and ultimately society.

The imagery I use to conceptualize the problem is the notion of rechargeable batteries. The doctor's batteries are drained every day, due to stressors they encounter, patients they have to take care of, the business of running their business, and so on.

Some days, the batteries are drained more than others. But the batteries are rechargeable, and so each day, the physician can "plug in" via time with their family, exercise, relaxation, hobbies, and be ready for the next day.

Burnout occurs when the batteries are not able to be recharged, and the physician must carry on with depleted amounts of energy. Ultimately, this becomes a crisis.

The causes of this problem are well documented and will be mentioned briefly. Is it the problem of the batteries or is it the charger that isn't working properly? In other words, is the physician not practicing proper self-care (batteries) or are the problems systemic to the organization (charger)? Of course, it is a bit of both.

Solutions are multi factorial, with the major most important first step being a recognition and acknowledgement of the problem. Solutions are to be found not only with improving the doctor's coping mechanisms, but also with the organizational structures recognizing the problem, and working as partners in improvements. Although it may be the physician who experiences the burnout syndrome, everyone suffers from it.

~~~~

Executive Director Retires

ACEP Executive Director and CEO Sue Sedory, MA, CAE, will be retiring May 31st. The Section wishes Sue the best as she explores retirement.

~~~~

Enough
Jay Kaplan, MD, FACEP
November 2020

I've had enough
enough fear
enough grief
enough sadness
enough uncertainty
maybe not enough anger
and it goes on
and truth
there is little I can do
other than to continue to spread
~~~~

While coping mechanisms can be improved with meditation/mindfulness, exercise, nutrition, cognitive behavioral therapy, schedule adjustments, and lifestyle changes, the inherent stressors of the job, including severe stressful situations, poor payment, the threat of corporate medicine swallowing up private practice, administrative burdens, electronic records issues, and much more can become overwhelming.

what hope I can muster
what love I have in my heart
to as many people as I can
to live with integrity
and gratitude
and
to consistently remind myself that
the glass is half-full
if I allow it to be so.

Letter from the Chair: Recap of LAC24
Stephen Anderson, MD, FACEP

I just returned from one of my favorite ACEP meetings, LAC24, where seeing some of you and networking with others remain highlights of the event.

Early on in my career, I was wide eyed at the opportunity to actually meet a congress(wo)man or senator, and I named LAC the 'You Can Talk to an ACEP President Assembly.' This was where I really began to bond with ACEP leaders outside my training site and state. As I aged, LAC became even more special as I developed a true passion for championing policies that improved my patient's outcomes, my community, my workplace, and my professional security. My enthusiasm for advocacy remains, but today I recognize the great opportunity for mentorship this event affords. Now that I can visit Congressional friends, with whom I have built a relationship built on trust and engagement, I truly LOVE this meeting.

This year was no less exciting than previous ones, as issues of boarding, workplace safety, physician due process rights, and yes, Medicare cuts were our Hill assignments. The 2024 asks seemed easier though, especially regarding physician compensation. We weren't focused on "pay raises," since most legislators understood our recruitment and retention difficulties are due to continuous cuts. They were even receptive to the idea of linking physician payment to inflationary standards in health care (a COLA if you will).

Everyone I talked to was aware of the boarding balance and fulfillment and one on Hospitals As Naloxone Distribution Sites (HR#5506) with an explanation of E-QUAL tracking data.

BUT… the session that garnered the most attention was ACEP President Aisha Terry MD, FACEP's sit down with Representative Greg Murthy, MD (R-NC).

Dr. Murthy was invited to speak because, for years, he has been an advocate on the Hill for physician compensation. He did not introduce the "Embracing anti-Discrimination, Unbiased Curricula, and Advancing Truth in Education (Educate) Act" until AFTER ACEP extended the invitation. This Act would, among other things, remove funding from any medical school referencing diversity, equity & inclusion.

ACEP has repeatedly endorsed DEI through policies and practice, and Dr. Terry did an amazing job of defending these policies and our stance with professionalism, data, and compassion. She inquired why the legislation and Murthy's comments are focused on race alone when DEI covers so much more. True of most politicians, he never really answered the question, which (for those of you who were not there) led to the rather odd monologue that covered a lot of territory, including race, the origins of Covid, Nazi Germany, single mothers, and the indoctrination by his own college alma mater.

In this session, Dr. Terry showed us many reasons to be grateful that she is our current ACEP president.

Hopefully others in this Section will continue to attend LAC – the next dates are April 27-29, 2025.

crisis and that it wasn't EM's "fault." They recognize that hospital crowding back flows into the ED, where there is no way to shut off the "inflow." Thanks to ACEP, a White House/CMS task force has been assembled to address the problem.

The issues of workplace safety were nicely punctuated by members of the Emergency Nurses Association (ENA), who were visiting the Hill at the same time we were.

Finally, there was the usual education and "exposure" at this meeting. Personally, I was thrilled to attend AAWEP's session on life

It clearly is an opportunity for us to prevent burnout and REMAIN RELEVANT.

~~~~

Never worry alone.

– Harvard psychiatrist, Thomas Gutheil

~~~~

Curmudgeon,
it's not just a word,
it's a lifestyle!

Physician Burnout or Overutilization of Physician Cognition?

Deepjot (Dj) Singh, MD, MMM, FACOG

It takes a minimum of 12 years to produce a physician. There is no medical equivalence to this training and degree. Our cognition and "watchfulness" are also burdened with overseeing our non-physician practitioners who, although helping us tremendously, are also burdening our cognition by giving us more to oversee.

The lines blur here with the corporate practice of medicine - the need to see more patients, more throughput, rigid schedules, and demands that are not focused on the patient or healthcare. Yes, we all must pay the bills, but sometimes the investments are skewed.

I wanted to discuss my journey that started as a solo private practicing ob-gyn for 20 years. I love what I do, I love my community, fellow staff, physicians, and patients. I do not like the obstacles and hurdles put in place that do not allow me to see my patients safely and efficiently.

When I was solo, I usually took all my calls and rotated weekends with other private practices. I have had the pleasure of seeing over 10,000 patients and counting, including my hospital required pre- authorizations. I started noticing more patient-entitlement and online "reviews" that were lies that made me want to be on anti-depressants. Eventually, I stopped reading them.

I would obsess about the reviews; knowing I had bent over backward, but it was an insurance issue, and that the patient's anger was misdirected. I started feeling lonely and burned out. I started feeling like I was being attacked and my mental burden and cognition were being affected. How could I feel less lonely? Were others feeling the same way? Was I too siloed?

The next step that helped me was getting involved (at first reluctantly) as chief of the department. I just wanted to see my patients and take care of them, so this was initially not on my radar. But I realized physician input regarding clinical care was needed in many areas and departments. I learned about policy, safety, and administrative issues crucial to safe patient care.

It was wonderful talking to colleagues and meeting physicians in other disciplines at the hospital. I was feeling less lonely. We would meet and catch up in the doctor's dining room, learn about our patients from different perspectives, and make sure we were all doing ok in our personal lives.

This led me to the crazy idea of going back to school and getting my MBA at the age of 47. Again, many told me, "you are already a doctor, why do you need

work-family of physicians, nurses, and staff. They had my cell number and could reach out to me anytime. Nobody abused the system.

But I was not burned out! I was able to get married and have a family, even after many told me I had "balls" to start a private practice.

Solo practice required teamwork, and I had wonderful well-trained staff and a supportive family to help me on this journey. But things started changing when the insurance payments began to depend partly on 'scores,' and there were more denials from payors on already ridiculously low payments that

another degree? Why do you want to go back to school?"

As physicians, we are every learners and teachers. I had the calling to go back and learn more and use different parts of my brain. So, while still in solo practice, I went back to school. I took a physician-only program, and my multi-disciplinary cohort of physicians from all over the world was amazing. I would get rejuvenated just going to class, being with classmates and discussing how we could better align values, all the while managing urgent issues like taking call back at our physician jobs.

During the master's program and even after I started getting involved with ACOG, my society needed me to let them know what the growing challenges contributing to burnout were for frontline physicians - lower payments with no COL increase in 20 years, higher medical malpractice rates, higher overhead, EMR debacles, more administrative burdens, and liability that should not have been put on our physician plates.

It sounds familiar in all specialties. Frontline physicians were not being heard!

Then Covid happened. I probably do not need to say anything about this, but as we became isolated and lonely, again, more was put on our plate. The plate will eventually get too heavy, fall, and break.

No words can describe why we needed the Dr. Lorna Breen Health Care Provider Protection Act.

While we advocate for our patients, we also need to advocate for ourselves.

Seek out opportunities for talking to your colleagues and other specialties and meet regularly in the doctor's lounge or dining room if you have one. You can do this even if you are introverted. If you do not have a hospital

Physician Burnout

Omer Deen, MD, FACG, AGAF, CPNS
Board Chairman, Physician Assoc. of CA
Immediate Past President, Los Angeles County Medical Association
Fellow, Am College of Gastroenterology
Fellow, Am Gastroenterological Association
Diplomat and Member, Board of Directors, National Board of Physician Nutrition Specialists

Physicians are taught to self-sacrifice, to put the health and well-being of our patients above all else. Simultaneously, we are actively trained in medical school and post graduate training to be blind to the financial differentials between our patient populations. We are encouraged and trained to see all of humanity as equal, making no differentiation between patients aside from physiological or pathological differences. This comes from a place of benevolence. Treat a homeless patient the same as you would the President. We take an oath which guides our practice. We sacrifice sleep, family, often our own health - ll to prioritize patient care.

However, as a side effect of this benevolent way of thinking, physicians are extremely ill-equipped to advocate for themselves, to understand the business and financial implications of the practice of

sponsored space for physicians, then do group dinner dates to catch up. Share your lived experiences with other physicians, join your specialty and state medical societies, and go back to what you like and why you went into medicine. For me, it's learning, taking care of my patients safely with decreased administrative and payor obstacles, and advocating for my colleagues to have fewer administrative burdens on their plates.

There is no shortage of patients. There is a shortage of doctors. We know burnout is more complex and nuanced than what I mentioned.

Don't let anyone tell you that you are not resilient. If you made it through college premed requirements, medical school, all the licensing and board exams, residency, and or fellowship - you are resilient.

medicine, including our position in the larger healthcare / insurance ecosystem.

While Americans have grown sicker, life expectancy has declined. Obesity, diabetes, cancer, and heart disease have all increased. In the setting of an increasingly sicker population, shortening patient visits and increasing the number of patients each physician is seeing on a daily basis seems irresponsible, doesn't it? But that is exactly what we are forced to do, whether independent or employed. Call it patient volume. Call it RVU-based payment. It's the same.

Declining payment for physician services has been relentless since 1981. Most people do not know that the 1981 Medicare fee schedule was more than three times the 2024 Medicare rates! No, that is not including inflation! Meanwhile, medical overhead, liability insurance, medical

legal lawsuits, inflation, and cost of living have all been rising.

This has forced physicians to sell their autonomy. Some quit practice and left medicine. Some took employed positions to swap their autonomy for a salary guarantee, others saw the only path forward as doubling and tripling their patient load to compensate and maintain autonomy. Today, more than 50% of American physicians are employed and are not independent.

Hospital systems have seen declining revenue and payment, as well. This has placed pressure on them to cut costs, increase revenue and maximize the volume of hospitalizations while simultaneously minimizing duration of each hospitalization. After all, if revenue per patient declines, the only way to try to maintain revenue is to increase the number of patients. It's just math.

But at what cost? Insurance companies have tightened their purse strings, pushing to minimize expenditures (withhold patient care) while maximizing their own

This loss of autonomy has come with loss of control over our practices as well as our patient's lives. Yet physicians have taken this in stride, collaborating with hospitals and healthcare institutions to help minimize cost/expenditures while helping to improve patient flow and maintain safe outcomes to optimize patient care. Physicians sit on hospital committees to help guide policy, almost always without any additional pay for their time.

The number of hospital administrators has risen exponentially over the past few decades to help meet the demands of insurance companies. There are more hoops to jump through in order for insurance companies to allow patient care. Physicians have found themselves spending more and more time charting, filling out paperwork, arranging post hospital care for their patients, working on prior authorizations, spending countless hours on the phone with peer to peer discussions for insurance companies to authorize and approve much needed patient care.

What is the main cause of physician burnout, you ask?

profits. Lobbying in state and national politics by insurance companies has steadily placed more and more authority in their hands and taken it away from physicians and patients.

Who decides what's best for patients? Doctors? Nope. Think again. It's the insurance companies. They decide which doctors you can or cannot see, which hospitals you can be treated at, what procedures you get, which specific medications in each medication class you can receive.

Physicians must fight insurance companies for their patients, now more than ever. Medication and procedure denials abound. Time consuming prior authorizations force physicians to use older outdated therapies first to prove failure before allowing better treatments. MRIs and other state of the art imaging modalities are often not initially covered by health plans either.

It is not one thing but a consistent general deterioration within the ecosystem of healthcare, beginning with insurance companies maximizing profits at the cost of covering healthcare. Physicians find themselves at the bottom of this pyramid, holding up the entire weight of the system to protect and advocate for their patients, while maximizing patient volume to try to begin to offset the declining payment for their services and time.

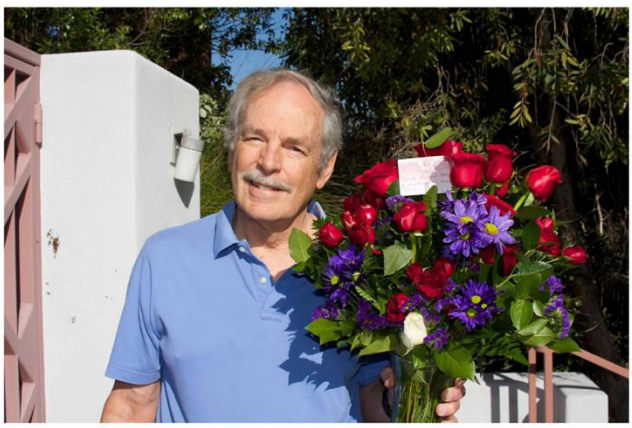
I commend my colleagues in medicine who, despite these increasing challenges, have always stepped up to save lives, protect their patients and do everything possible to maintain the quality of healthcare as best they are able in this system. But it cannot stand much longer. We can and must do better for patients, for doctors, for each other.

~~~~

Thank you to our guest authors

~~~~

Happy Mother's Day to all Moms!



A guy who went to medical school with me used to exchange Mother's day cards with me every year. One year, he sent me a bouquet with a Mother's Day card that went to the neighbors instead of me because I was not home to accept it. I got some "looks" from the neighbors. – John Bibb

The Most Powerful Force in the Universe
John Bibb, MD, FACEP

not feel that I could apply topical local anesthetic liquid without possibly getting it in his eye. We tried to wrap the child up in a sheet so we could get control of his movement and struggling. It did not go well.

Then mom took charge. She held her son next to her body with her arms wrapped around him. She was confident, loving, and supportive. Her son sensed this and was comforted.

I was able to anesthetize the wound. All went well after that. and suturing was easy. I have an unofficial award that I announce to great moms. It is **Mom Of the Day**.

This mom deserved it. And of course, I told her, to congratulate her for the great job she did as a mom.

~~~~

From the Editor: Reimbursement or Payment?
Pamela Bensen, MD, MS, FACEP
~~~~

According to astronomers, the universe is expanding, rather than contracting, as you might expect from the force of gravity.

In fact, the farther away something is, the faster and faster it is moving away from us. This repulsive force is so great that if it were converted to mater, as Einstein showed it could be, it would be more massive than every star, planet and galaxy we can see or imagine.
But for us humans, the strongest force in the universe is motherhood.

Mom can make all the difference for her kids in the ED. The mom of a disabled child will advocate for her child with tremendous force. Her child is going to get the best possible care from every nurse, doctor, and everybody else. Mom is an example to us of love and devotion. It makes no difference how grave the child's disability is. Love from mom is not based on how perfect her child is. It is just there.

Recently, I saw a five year old boy with a facial laceration near his eye that needed to be sutured. The child was very upset, and I did

Reimbursement, "the action of repaying a person who has spent or lost money. Noun: "a sum paid to cover money that has been spent or lost." (Oxford Languages) "Reimbursement is the act of compensating someone for an out-of-pocket expense by giving them an amount of money equal to what was spent." (Wikipedia) A reimbursement is not a refund or a payment as a result of overpayment or returning a product.

Pay as to "give (someone) money that is due for work done, goods received, or a debt incurred. (Oxford Languages) "Payment is the exchange of money, goods, or services for goods and services in an acceptable amount to both parties and has been agreed upon in advance. You can pay with cash, a check, a wire transfer, a credit card, a debit card, or even cryptocurrency."

In the early days of health insurance, patients paid the physician's bill, then submitted it to the insurance company. Insurance companies would reimburse the patient for all or part of the bill,

depending on the terms in the policy. Thus, the patient was compensated, indemnified, recompensed, repaid, or given "money or its equivalent in return for something." (Merriam-Webster Thesaurus)

Why then do we insist on referring to physician-payment as 'reimbursement'? And what does it have to do with burnout?

Insurers have found that this 'double speak' implies that they are magnanimously gifting lost funds to physicians. Physicians have not questioned the terminology and do not correct or even object to this linguistic distortion. Bottom line, today, everyone accepts the deliberate misuse of a clearly defined word.

'Physician' is a very old word, coming from both Greek and Latin roots for physic, meaning "natural science and medicine." The legal

What then is the damage caused by the mischaracterization of legitimate 'payment' as 'reimbursement'?

Perhaps by itself, there is no damage. But contemplate other linguistic changes, the use of the word 'provider', a supplier, a person or company that supplies goods or services (Meriam Webster) to refer to a 'physician'. Picture the usurpation, by midlevel providers, of responsibilities once reserved exclusively for physicians and the ever increasing non-clinical, physician required duties, coding documentation, peer-to-peer phone interactions to justify care and proofreading/correcting voice-(non)recognition generated medical records.

These micro aggressions rob physicians of their professional designation. This loss of personal identity eats physicians from the inside out and may be the least recognized etiology of burnout.

definition of a physician includes doctors of allopathic (MD) and osteopathic (DO) medicine, surgeons, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors within the scope of their practice as defined by state law.

Wikipedia tells us that "A physician, medical practitioner (British English),medical doctor, or simply doctor is a health professional who practices medicine, which is concerned with promoting, maintaining or restoring health through the study, diagnosis, prognosis and treatment of disease, injury, and other physical and mental impairments…Medical practice properly requires both a detailed knowledge of the academic disciplines, such as anatomy and physiology, underlying diseases and their treatment—the science of medicine—and also a decent competence in its applied practice—the art or craft of medicine."

While the degrees, qualifications, and role of the physician and the meaning of the word itself vary around the world, the common elements remain medical ethics requiring that physicians show consideration, compassion, and benevolence for patients.

While I am not an advocate for the return of the day when only physicians could start an IV and nursing staff stood when a physician entered the nursing station, I do mourn the loss of clear definitions of the words we use to describe who we are, what we do, and how we are paid for it. Without these definitions, it is impossible for us to communicate unambiguously. Without them we don't even know what to think of ourselves. And worse yet, patients don't know what commitment we are offering them when we care for them.

My commitment to my esteemed colleagues battling burnout: I will always call you 'physicians' or 'doctors.' and I will crusade by your side for respect and just payment from those whom you tend. You warrant the honors you work so conscientiously to deserve. And the satisfaction of a job well done and appreciated. Thank you for your professionalism and knowledge; your art and science of medicine.

Battle burnout - call me a physician!

RELEVANT in Vegas

The Section event will be a pub crawl. We are planning to meet the needs of "hearing challenged" members; have a "booth" in a vacation/travel/explore the world motif, please submit photos from exotic locations to exhibit; and lure new membership with regular & virgin margaritas. We need your help to secure funding/sponsorship.

Please email Steve your ideas.

We want to hold our annual meeting just before the pub crawl (Day 1) to get us together early in the Assembly to network/rendezvous. Business (4-6 pm) will include elections/results; a discussion on volunteerism and caregiving;

Council eBook) more easily. What would you change?

~~~~

And Finally,

What Do You Want to See in Our Next Executive Director?

Our own Sandy Schneider will serve as interim executive director and lead the search for a new ACEP staff leader.

Let's help her find us an out-of-the-box thinker with a track record for being quantum leaps ahead of the crowd. Someone who believes ACEP is still relevant to patients and the physicians who care for them during their everyday and life threatening
~~~~

sharing fun ways we are "exploring retirement" (5-10 folks sharing three slides of travel, projects, milestones) to make this feel like family.

~~~~

Imagine:

What if ACEP Went Away?
What would you miss most?

When ACEP first started, I would have said, "the education" because there was nowhere to get EM education. But today, I have to admit I would miss being able to go to one single place, the annual meeting, and hang out with all of you guys at once! Hugging old friends and meeting new ones. Like surprise cooking, no one knows what magic will happen when you combine different ingredients (EMPs, their SOs, and our totally dedicated ACEP staff).

Please send your thoughts, what would you miss most if ACEP weren't around?

~~~~

What Would You Change?
If you could change ACEP to meet your needs?

I would redesign the website to be user friendly and let me find things (like the emergencies. And make sure s/he has financial expertise to lead us through the next few years of fiscal frugality to put ACEP back on a firm course of financial stability.

What traits should our new exec have? Know anyone you think should apply?

~~~~

In Case You Missed These

Real Forces That Motivate Us in Healthcare

"While the practice of medicine is grounded in the physical body, the motivations and values that guide physicians often transcend physicality. The drive to heal, to alleviate suffering, and to improve quality of life are fundamental motivations for many in the medical field. These are not simply biological drives, but metaphysical ones, rooted in empathy, compassion, and a commitment to service…"

https://www.medpagetoday.com/opinion/second-opinions/109763?xid=nl_mpt_DHE_2024-04-21&eun=g2101270d0r&utm_source=Sailthru&utm_medium=email&utm_campaign=Daily%20Headlines%20Evening%202024-04-21&utm_term=NL_Daily_DHE_dual-gmail-definition

AMA Steps Forward®

"Open-access resources offer innovative strategies that allow physicians and their organizations to thrive in the new health care environment. These resources can help you prevent physician burnout, create the organizational foundation for joy in medicine, and improve practice efficiency."

https://edhub.ama-assn.org/steps-forward?gad_source=1

~~~~

Migraine Cured by Ice Cream?

For the migraine sufferers among you, have you seen this article?

Physician Suicide

by Louise B Andrew, MD, JD; Chief Editor: Barry E Brenner, MD, PhD, FACEP

~~~~

From Fred Dennis: "this link provides an interesting end stage comment on how burnout is affecting MDs."
https://emedicine.medscape.com/article/806779-overview

~~~~

Dementia
Our Next Explorer Issue

https://www.peoplespharmacy.com/articles/how-to-stop-your-migraine-by-eating-ice-cream?utm_source=The%20People%27s%20Pharmacy%20Newsletter&utm_campaign=5b758d602a-EMAIL_CAMPAIGN_2024_04_30_03_30&utm_medium=email&utm_term=0_7300006d3c-2aca2df05f-%5BLIST_EMAIL_ID%5D	In an effort to help all of us who are dealing with dementia, either in ourselves or a loved one, our next issue will be devoted to articles on dementia. Debra Perina, MD, FACEP will compile your commentaries, thoughts, ideas, and issues related to dementia. Remember, we can memorialize your thoughts, if you send them to us. If you have experienced life with dementia, help your colleagues. Tell us how you solved the problems you faced with dementia. Send us your wise words. ~~~~